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# Techniques for Improving Client Relations in Family Planning Programs

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Four techniques for improving client relations that should be part of systemic change — not applied like bandaids — to make family planning services more effective.

This paper — a product of the Population Policy and Advisory Service, Population and Human Resources Department — is a background paper produced for the “best practice” paper on effective family planning programs. Copies of this paper are available free from the World Bank, 1818 H Street NW, Washington, DC 20433. Please contact Ofilia Nadora, room S6-065, extension 31091 (September 1992, 32 pages).

Demand for children and demand for contraceptives are not independent of the system of supply. And client transactions are the major means for lowering costs. Family planning workers, providers of services and mass media campaigns, are the harbingers of new ideas and new delivery systems that could modify the demand for fertility regulation and patterns of contraceptive use.

Simmons, Koerber, and Simmons describe four broad techniques for improving client relations, emphasizing their potential as entry points into program development (systemic change). These techniques are presented as a sampling of experience that can be brought to bear on dysfunctional client relations. Among examples described:

*Patient flow analysis (PFA).* A self-administered time-and-motion diagnosis that allows computerized documentation of patient flow and personnel use in health service clinics. Using relatively unobtrusive data collection, PFA seeks to get a representative snapshot of a program and its dysfunctions, replicating a “typical” clinic session. Data are later diagnosed and remedies proposed for bottlenecks and inefficiencies.

*Training and visit (T&V).* A managerial approach for dealing with geographically scattered outreach programs. The four main principles of T&V: focus on a few key tasks, frequent in-service training and supervision, regularity and predictability, and face-to-face communication. The T&V model focuses on what workers should be doing with their time in the field to meet client needs. A goal of T&V: to

enable all clients to name their worker and the day of the week s/he visits, and identify a few themes from their most recent encounter.

*Activity planning.* The antithesis of T&V, activity planning calls for abandoning rigid time-place-movement schedules and specific messages and replacing them with a fluid work schedule adapted to local conditions. Workers must be well-trained in collecting data, listening and building rapport, and communicating with conviction. The quality of the worker-client relationship is all-important. A weakness is that if the workers have no objective they lose control of the exchange with clients.

*Training and worker empowerment.* Training by itself is not enough for systemic change — training for what? But training can serve as an entry point into organizational development when it is rooted in methodologies that help to develop the participant’s technical and interpersonal skills and ability to innovate. But training must be accompanied by changes in the system of supply that supports and facilitates innovation and quality of care.

Techniques to improve client relations can address either the client-provider interface directly or the system of underlying determinants. It is important to ask basic questions: Is the idea to “fix” a single worker-client dysfunction or is it to provide a continuous program for modification and growth? Who will be affected by the change? Who or what will be responsible for initiating and overseeing the course of action? What are the short- and long-run goals of intervention?

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IN FAMILY PLANNING PROGRAMS

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## I. Introduction

In the ongoing and controversial effort to understand and improve family planning programs, client-provider relationships, have proved consistently relevant and yet largely neglected. An improved understanding of the program-client interface has important implications not only for addressing questions about the demographic impact of program intervention, but for strengthening and fine-tuning these programs in the interests of both clients and providers.

Systematic examination of the relationships between program representatives and members of the client population have consistently revealed that they merit considerable improvement. A discussion of techniques that might produce such improvement is an important endeavor and will be attempted in this paper. While techniques for effecting this much-needed improvement have been successfully utilized in various developing country programs, a caveat about their application must be issued from the beginning. Client-provider interactions are the production function of family planning programs, and as such are only as good as the systems, especially the set of management relationships, from which they arise. Therefore, techniques for improving client relations cannot be viewed independently of the management process within which they are implemented, nor separate from the larger programmatic environment of service supply and demand.

Furthermore, because these relations are embedded in systems, any formula for their improvement must be systemic in focus. It must not only address the whole system of client relations and their antecedents, but it must do so in a continual and evolutionary manner. Genuine and long-term improvement in client relations will stem from the organizational development, growth and change of whole programs. As such, successful techniques are not one-time panaceas, but merely entry points into a continuous process of observation, diagnosis, and corrective actions that produces sustained program development. They must be applied with discretion, and an eye to fostering a larger, ongoing process of change.

In light of the continuing debate concerning the causal relationship between program effort, contraceptive use and, ultimately, fertility decline, this paper takes as its premise that programs can and do play an important role in affecting fertility behavior and demand for services.<sup>1</sup> The obstacles and constraints to developing meaningful programs, however, are daunting. Evidence from Matlab and elsewhere suggests that client relations, if appropriately structured and supported administratively, can exert an independent impact on demand (R. Simmons et al., 1988). Often, however, the administrative acumen and strength to sustain effective client-provider interactions may be lacking in precisely those situations where they are needed most. Where programs can potentially have the greatest impact in mobilizing latent demand and generating new interest in contraceptive use, the same low level of development that

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<sup>1</sup>For a detailed discussion of this argument see Lapham and Mauldin, 1976; Berelson, 1974.

suppresses demand for services often limits the degree of administrative efficacy in supporting effective client exchanges.

Given the importance of these administrative and developmental obstacles, we begin this paper with a conceptual framework which places client relations into a broader, systemic context. This framework summarizes a more detailed discussion of client relations and the proximate operational determinants of fertility found in Simmons and Phillips, 1992. Illustrative findings from the available literature on the current status of client relations in Third World family planning programs are included in this part of the paper. Subsequently we review insights from the literature on organization change and development in order to provide the necessary background for the discussion of improvement techniques. Finally, we discuss a selective sampling of specific improvement techniques, as entry points into this process of organization-wide change, describing not only their key characteristics, but also their appropriateness for various programmatic and managerial contexts.

## II. Conceptual Framework of Client Relations

### *Client Transactions/Client Relations as Proximate Operational Determinants*

Initially, the distinction between client relations and client transactions must be clarified. Client transactions refers to all interactions between programs and their audiences, that is interactions that are both personal and impersonal in nature. Client relations, the subject of this paper, are a subset of client transactions, that encompasses only exchanges that are interpersonal in nature<sup>2</sup>. Clients interact with programs personally and directly through exchanges with outreach workers, volunteers, medical and paramedical personnel and other staff who promote contraceptive use, provide services and information and/or auxiliary medical services (Simmons et al., 1986). Client relations exclude, therefore, one-sided and impersonal informational and supply distribution efforts, including radio and other mass medial efforts, mailings, enlistment of major political and cultural figures to promote intervention efforts and other impersonal interactions.

Any and all interaction between organized family planning programs and their reference population, including audience reception of media messages, worker-client exchanges and use of political and cultural events for program outreach, fall within the larger rubric of client transactions. As such, client transactions, including client relations, must be considered the proximate operational determinants of contraceptive use, analogous to the proximate determinants of fertility described in the demographic literature (Bongaarts, 1978; Davis and Blake, 1956).

For the system of supply illustrated in Figure 1 to have any impact on contraceptive behavior, it must be exerted through these interactions between the program and client population (Simmons and Phillips, 1990). Client transactions are

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<sup>2</sup>For the purposes of this paper, we define client relations more broadly than Bruce, 1989.

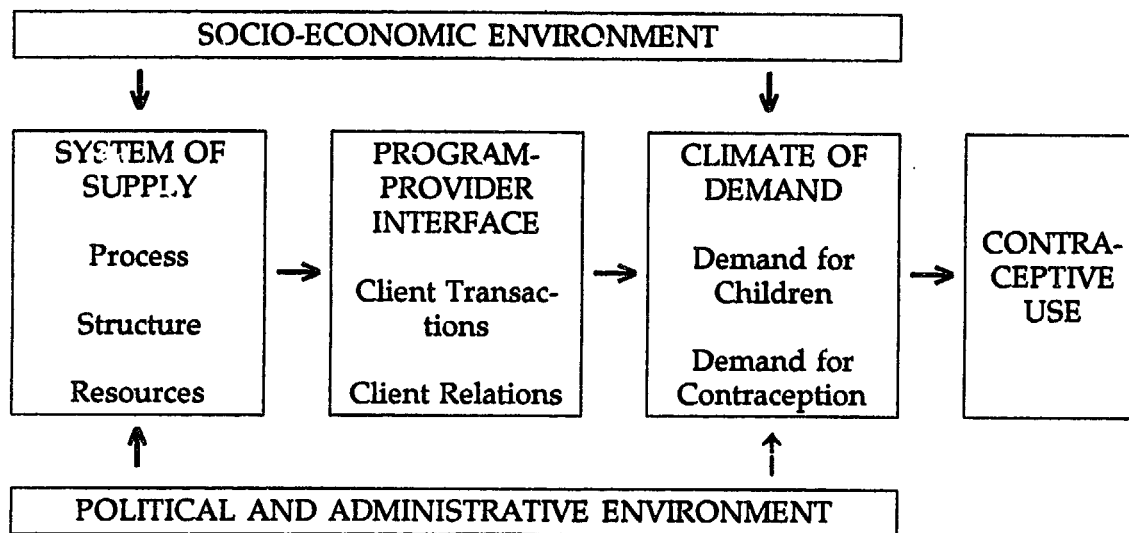


Figure 1. Conceptual Framework for Client Relations

causally closest to client behavior of all the supply side variables depicted. Operational determinants and the more distant policy, managerial and administrative factors constitute the context in which client transactions are embedded. Indeed, client transactions cannot be considered separately from these supportive factors, which mold them. They are the pathways through which the effects of the more distant operational and administrative variables must travel in order to influence contraceptive use.

Because client transactions are formally designed by the system of supply, and are fundamentally shaped by the management process through which they are implemented, any attempt to improve client transactions (and their subset client relations) must be fully cognizant of this relationship. Furthermore, as illustrated in Figure 1, client transactions are also influenced by the socio-cultural, institutional and political/administrative context in which they are situated.

This systematic view of client transactions is incomplete without reference to the relationship between client transactions and demand. It has been our contention elsewhere (Simmons et al., 1988) that client transactions play a more central role in motivating and facilitating contraceptive use than merely mobilizing latent demand through convenient provision of contraceptive supplies. Demand for, and supply of, contraceptive services are not necessarily mutually exclusive determinants of contraceptive use and subsequent fertility regulation. Instead they jointly mold the climate for decision-making about contraceptive use.

For the purposes of definition here, the climate of demand can be decomposed into demand for children and demand for contraception. This demand is not independent from the system of supply. The literature supports the notion that contraceptive use is associated with a broad range of economic, psychic, social and cultural costs (Bulatao and Lee, 1982). The system of supply can exert an independent

impact upon these costs and lower them, thus altering the demand for contraception. Client transactions, as the proximate operational determinants, are the major means through which these costs are affected. Family planning workers, providers of services and mass media campaigns are the harbingers of new ideas and new delivery systems that may play a role in modifying the demand for fertility regulation and the patterns of contraceptive use.

The resulting changes in contraceptive behavior, it must be noted, may not always be accompanied by a more fundamental change in attitudes or beliefs about fertility and family size norms. The impact of family planning programs in many instances may be limited to that of a superficial behavioral change. Nonetheless, targeted program intervention can reduce the associated economic and health costs of contraceptive use through facilitating access to supplies and medical back-up. Even the mere presence of family planning workers in some communities may set in place certain larger ideational changes concerning the status of women, the role of families and other "modern" themes that interact ultimately with the costs of fertility regulation (Mita and Simmons, forthcoming).

This framework, although only briefly summarized here, draws extensively on earlier conceptual work concerning client transactions, programs intervention and contraceptive use (Simmons et al., 1975, 1986; Simmons and Phillips, 1990; Simmons and Simmons, 1990). It is also, we believe, entirely consistent with the conceptual framework presented by the U.S. National Academy of Sciences (NAS) volume on family planning effectiveness (Lapham and Simmons, 1987) that identifies demand for fertility control, policies and programs, and client transactions as formative influences on the traditional proximate determinants of fertility. The relationships set forth in Figure 1 shall be used to guide discussion of techniques for effecting improvements in client transactions and relations.

### *Characterizing Client Relations*

Some basic distinctions and key elements for classifying client relations are introduced below (Simmons and Simmons, 1990), including examples and illustrative findings from the literature on existing relations in Third World family planning programs.

1) **Actual versus planned transactions.** Not all personal interactions that transpire between program representatives and clients are formally planned. Planned transactions are exchanges that are anticipated or spelled out in program documents and design, and they may vary considerably from the actual exchanges that take place. A similar distinction has been made between policy level and point of service transactions, which can also represent the significant schism between what is conceived and what is carried out in terms of client interactions (Kumar et al., 1989).

Evidence from developing countries bears out the hypothesis that discrepancies between actual and planned transactions are real and significant. A comprehensive analysis of family planning in one division of Uttar Pradesh, India, for example, found that an ambitious program design specifying regular visits by family planning workers



to all eligible households was not necessarily translated into actual coverage of the target area. In fact, only 13 percent of husbands and 7 percent of wives interviewed reported ever being visited for family planning (Misra et al., 1982). Other reviews of family planning programs have found a similar pattern of workers, overwhelmed by large geographical work areas or poorly motivated by low pay and a corrupt employment system, failing to fulfill the regimen of planned relations laid out for them (Rao, 1977; Bhatnagar and Gupta, 1980; Simmons et al., 1984; Afzal et al., 1987).

Because the deviation of actual client relations from planned ones is often significant and pervasive, it is essential that efforts to improve client relations be fully informed of the actual nature of these encounters. The application of techniques without prior analysis of actual client relations is misguided. The choice of technique for improving client relations must be adapted to the actual conditions prevailing at the client-provider interface, and not merely reflect those which are planned but not necessarily realized. Actual client relations must be observed, documented and analyzed, and the degree of deviation, whether positive or negative, from intended design understood if the client-provider relationship is to be truly improved.

2) **Client versus provider initiation of transactions.** Although client relations involve the interface of programs and their intended beneficiaries, the nature of this interaction is likely to vary significantly depending on whether the exchange is client-or program-initiated. Family planning programs can include both types of transactions. For example, a visit by an outreach worker to a household would be considered a provider-initiated contact, whereas a woman presenting herself for services at a local clinic implies client initiation.

The socio-economic and political/institutional contexts of programs are key in determining whether client or provider initiated transactions are more appropriate. In settings where the demand for services is weak, there is an opportunity for using provider-initiated exchanges to stimulate interest, familiarize clients with services and perhaps even introduce new fertility norms and legitimate family planning use. On the other hand, where the demand for contraception is already robust, there will be a lesser role for program outreach, and more emphasis on responding to client-initiated contacts. Awareness of the larger setting of these transactions can positively guide efforts to develop appropriate program strategies.

The predominant mode of initiation also has important implications for their modification. Provider-initiated contact implies a considerable organizational burden because the program must actively reach out to the client population. Client relations in this mode will be extra sensitive to the strengths and weaknesses of the managerial factors facilitating them. For example, supervision in a worker outreach program is considerably more difficult to implement and modify than supervision in a clinic based program where clients initiate contacts. Choosing a technique capable of fostering improvement in client relations must be guided by the knowledge of whether these relations are primarily provider or client initiated. Some of the techniques discussed in this paper, such as Patient Flow Analysis, are relevant for clinic delivery of services, settings where contacts are predominantly client initiated. Techniques such as activity

planning and Training and Visiting, on the other hand, are directed at client relations where contacts are program initiated through worker outreach.

3) **Categorical versus integrated services.** This variable examines the question of whether or not family planning services are offered by themselves, or in the context of broader range of health and/or other social services. Some programs, particularly those employing outreach workers, may opt to offer an array of services broadly related to health and family planning. In Matlab, for example, community health workers not only provide injectables, pills and condoms, they also distribute ORS packets, assist in prenatal and delivery care and refer for more serious medical conditions they cannot treat (Simmons et al., 1988). Other instances of service delivery, such as the family planning safaris organized by the BKKBN in Indonesia, are limited solely to contraceptive provision (Ward et al., 1990).

This paper does not engage into the debate concerning the appropriateness of integration in promoting contraceptive use, but merely attempts to underscore that the type of service delivery, and the service context of family planning outreach, will have bearing on efforts to modify the program-client interface. Choice of technique should be affected by the service delivery context, especially if this is judged to be a source of dysfunctional client relations. If, for example, workers receive a hostile reception, one must ask how much change can be produced by affecting the manner in which existing services are delivered, and how much by changing their content.

4) **Simple versus complex transfers.** Programs, and their resulting interface with clients, can be additionally classified by the degree of complexity of both the messages and services they seek to deliver. Organized family planning programs can run the gamut from narrowly focused campaigns to promote a single method for a single purpose to offering a complex package of services for differing users, often with complementary health and child survival themes.

One important measure of this complexity with direct relevance to client relations is the amount and profundity of the information transferred to users.<sup>3</sup> Programs vary considerably in the quantity, quality and complexity of information that accompanies service delivery. In general, studies of client relations have found the amount of information transferred from providers to client insufficient, particularly regarding side effects of methods. Workers often believe that clients do not need to know much about their method, that they won't understand information that is given to them, or that too much information on side effects will scare potential acceptors away (Gay, 1980; Ainsworth, 1985; Ward et al., 1990).

A related, but distinct, issue is that of the degree of choice in contraceptive methods offered within one program (Bruce, 1989). Program advocates often fall into two opposing camps, one championing simple designs focused on promotion of one or two methods, the other arguing that both demographic impact and quality of care are

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<sup>3</sup>The importance of this factor has received central emphasis in Bruce's elements of quality of care. See Bruce, 1989.

enhanced by a broader and more complete range of services. Even in instances, however, where a broad array of methods are nominally available, workers' preoccupation with targets, or program biases towards certain methods, especially more effective methods, may limit the actual choices a client has (Ainsworth, 1985; Rao, 1977; Ward et al., 1990). While there is no agreement on which model is more universally appropriate, there nonetheless may be instances where one form of services, and hence one type of client interactions, may be best suited to the larger climates of demand and supply. A concern with techniques for improving the client interface must address these questions, especially the issue of choice.

**5) Direct versus indirect interactions.** This is conceptually perhaps the most difficult dimension of client relations to characterize. While client relations by definition refer to direct interpersonal contact between program representatives and client populations, the ultimate beneficiaries of these relations may be reached indirectly. Direct relations refers to exchanges between program staff and actual or potential users. In some cases, however, interactions with clients may impact other users of contraception indirectly, through informal familial or extra-familial communications that eventually affect contraceptive use.

This latter model may be particularly relevant for non-traditional targets of direct program outreach, such as unmarried or nulliparous women, and for settings where women's behavior and interaction with non-family members is especially constrained. Preliminary evidence from Matlab suggests that worker-client exchanges may be observed by adolescent and unmarried girls, that is by unintended beneficiaries who gain knowledge indirectly from the program (Mita and Simmons, forthcoming). In addition, the presence of family planning programs, and program representatives, may, in some instances, set in motion a process of diffusion of fertility and contraceptive-related ideals whose scope far exceeds direct participants in staff-client exchanges. These indirect beneficiaries of the program-population interface have been poorly studied, and this dimension of client relations merits greater recognition. Techniques to address client relations should be cognizant of the primary mode of message dissemination, whether direct or indirect, as well as the total profile of the client audience.

**6) Quantity and quality of interactions.** Client transactions can be classified on both a quantitative and a qualitative dimension.

*Quantity.* From a quantitative perspective, there are three parameters that can be measured: the frequency of interaction, the duration of the exchange and the period of time over which the interactions transpire. As evidence from selected family programs shows, these parameters vary significantly. Contact between program representatives and clients may be regular or haphazard, infrequent or predictable, and brief or continuous, subject to various programmatic and environmental factors.

The quantitative profile of current client relations in developing country programs is not a sanguine one. A review of client relations in Latin America showed that often interactions between doctors and their patients could be measured in seconds rather than minutes. A common complaint of clients was that they did not spend enough time with providers (Gay, 1980). Other reviews have also revealed relations to

be short and limited (Beeson et al., 1987a; Rao, 1977; Koblinsky et al., 1987). While sometimes relations can be predictable, as is the case in the Matlab family planning program where workers follow set schedules, they are frequently not, as was illustrated in the Kanpur study (Misra et al., 1982). Coverage of the target area is often incomplete (Bhatnagar and Gupta, 1980; Misra et al., 1982; Rao, 1977), and follow-up with clients poor (Ainsworth, 1985).

This classification scheme makes few judgments regarding appropriate quantitative values for client relations, but rather suggests this dimension as an avenue for describing and modifying the program-provider interface. If client relations are perceived to be too infrequent or unpredictable, then a technique such as Training and Visiting, with its rigorously scheduled pattern of visits may be appropriate, whereas long waiting times would be better addressed by a technique such as Patient Flow Analysis.

*Quality.* Much has been written recently about the quality of care that programs offer, reflecting a continuing preoccupation with the client's perspective on service delivery and a shift away from purely demographic objectives of programs (Bruce, 1989; Kumar, 1989; Jain, 1989; Simmons et al., 1990). Within our classification system, the qualitative dimension of client relations refers to the manner in which the interaction is conducted, and includes notions of technical and interpersonal quality of care, empathy, trust, respect, protocol and social distance between provider and client.

To date, the qualitative dimension of client relations has remained weak in programs, a fact which is well illustrated in the literature. Observations of provider-client exchanges have shown that workers are often lacking in interpersonal communication skills (Rao, 1977; Bhatnagar and Gupta, 1980; Ainsworth, 1985), are insensitive to client needs and feelings (Gay 1980; Rao, 1977) and that the large gulfs in social class that frequently separate clients and providers exacerbates this insensitivity (Beeson et al., 1987, 1987a; Gay, 1980). In instances where providers and clients are of similar social backgrounds and status, the quality of interactions seems to benefit (Gay, 1980; Simmons et al., 1986). Technical quality of care in the provision of services is also commonly ignored or incompletely assured (Ward et al., 1990).

Quality of care, as defined by Bruce and others, and client relations are highly interrelated concepts. Conceptually, the two both address the interface between programs and clients indicated in Figure 1. The six quality of care variables identified in Bruce, 1989—choice of methods, information given to clients, interpersonal relations, technical competence or quality, continuity and follow-up, and appropriateness of the service constellation—all refer to dimensions of client relations. In fact, each of these six elements are included in some form under the framework for defining client relations established here.

The differences and similarities between the quality of care and our client relations framework are subtle, and merit clarification. Each sets out to accomplish both an analytical and prescriptive task. This analytic task is clearly spelled out in the client relations framework, through the classification scheme delineated above. It seeks not only to provide a comprehensive profile of client relations, but also to situate the

interface within its determinants. We argue that client relations must always be first observed, documented and their determinants understood, before they are modified. These analytic tasks are to some extent implicit in the Bruce quality of care framework, although less central a theme.

The prescriptive dimension of each framework—deciding what is appropriate at the interface, and what constitutes quality in client relations—is united by a deference to professional judgement about acceptable standards of care. That is, each framework holds that, regardless of client or provider concerns, there are certain standards of care that it would be ethically untenable to ignore, especially those concerning technical quality of care. For example, use of aseptic technique and complete disclosure of information on side effects cannot be neglected in any program. Other judgments about the goodness and badness of care are made from the users' perspective. From this construct, for example, additions to the range of available methods—broadening choice—are argued to increase the quality of care, because it increases options for clients. The user perspective constitutes the central set of criteria in the Bruce framework. The client relations framework, in contrast, makes judgments about appropriate strategies at the interface based on what is desirable in the climate of demand, the user population, and what is feasible in the system of supply. This framework posits that quality of care represents in some sense a trade-off between what administrative and managerial systems can support, and what clients want. If broadening the choice of methods places an undue burden on the system of supply, and adversely affects overall standards of care, it may not improve the interface.

### *The Determinants of Client Relations*

Traditional wisdom holds that finding the source of a problem is at least half of its solution. Similarly, the improvement of client relations cannot be addressed only symptomatically. Because of the multitude of forces shaping these interactions, dysfunctions manifested at the level of client relations are often rooted deep in the administrative and institutional systems supporting them. Intervention techniques must be therefore be judged on their appropriateness given these underlying problems and weaknesses, and not merely for their relevance to symptoms at the interface. Techniques for improving client relations are not always most appropriately addressed at this level, but rather to a deeper level within the organizational or management system fostering these interactions. As will be argued later, a best fit solution might be one that calls for a combination of changes throughout the system of client relations and their programmatic determinants. We outline here, therefore, a framework of the determinants of client relations, to make possible a holistic view of client relations as embedded in a larger managerial and institutional context, and to facilitate their systemic improvement within this matrix.

Client relations are not exogenous forces independent from the remainder of the program and population environment, but rather are nested in a complex web of internal and external determinants. The nature of client relations, including variations along the dimensions identified above, arises from two interrelated sets of forces: the organization of the health service system and the socio-cultural and political/administrative or institutional context within which this health service system is

situated (Simmons and Simmons, 1990). This relationship is conceptually illustrated in both Figures 1 and 2, where client relations are both informed directly by program factors or the systems of supply, and more broadly by larger environmental variables. For the purposes of this paper, it is the former set of forces, the programmatic, and specifically the managerial, context of client relations that is of greatest significance. Client relations are fundamentally shaped by the management and administrative systems which surround and support them, and are subject to the constraints and opportunities inherent in these systems.

From an organizational perspective, family planning programs are systems of several interrelated and interdependent elements residing in a complex external environment. Not only are client relations determined by internal programmatic factors, they are additionally molded by external, environmental forces as well, illustrated by the feedback loops in Figure 1. Larger socio-economic, political and cultural influences work upon client relations through a variety of causal paths. On one level, they affect the program itself—worker's behavior and expectations, socially-defined relationships between clients and workers and the type of services offered. Similar societal influences also affect the policy and management system that supervises the worker. At the same time, however, these sets of forces determine how clients will respond to the program and worker's initiatives (Simmons et al., 1986). Programs are conceived not independently, but are fundamentally guided by the institutional, political and social systems that give rise to them. Nor do the intended beneficiaries of these programs make decisions in vacuum; their behavior is influenced on several dimensions by their cultural and socio-economic setting. Client relations, situated as they are at the interface between programs and clients, are uniquely exposed to a variety of societal forces from not just one or two but several sources. Failure to recognize this complex matrix of determinants will handicap efforts to influence these exchanges.

Despite the apparent overwhelming complexity of the determinants of client relations, the following four broad categories of variables can be distinguished. Categories i-iii are program factors, while category iv attempts to encapsulate all the larger social, cultural, economic and political/institutional forces external to programs. This framework for conceptualizing the determinants of client relations owes much to the strategic management theorists, who argue that organizational behavior and performance must be viewed systematically, and understood in terms of the environment, strategy, structure and processes guiding operations (Paul, 1982; Khandwalla, 1977).

- i. *Management process.* Management processes, in the strategic management framework, refer to all the actions taken by managers to motivate and mobilize their human resources (Paul, 1982). Included under this category are such variables as leadership and supervision, decision-making processes, management information systems, staff motivation, participation and rewards, record-keeping, logistics, and work flows. The relationship between management processes and client relations is an obvious one; the behavior and conduct of programs representatives who deal with clients will be greatly influenced by the leadership, support and supervision they receive, the rewards and punishments merited out by programs and workers'

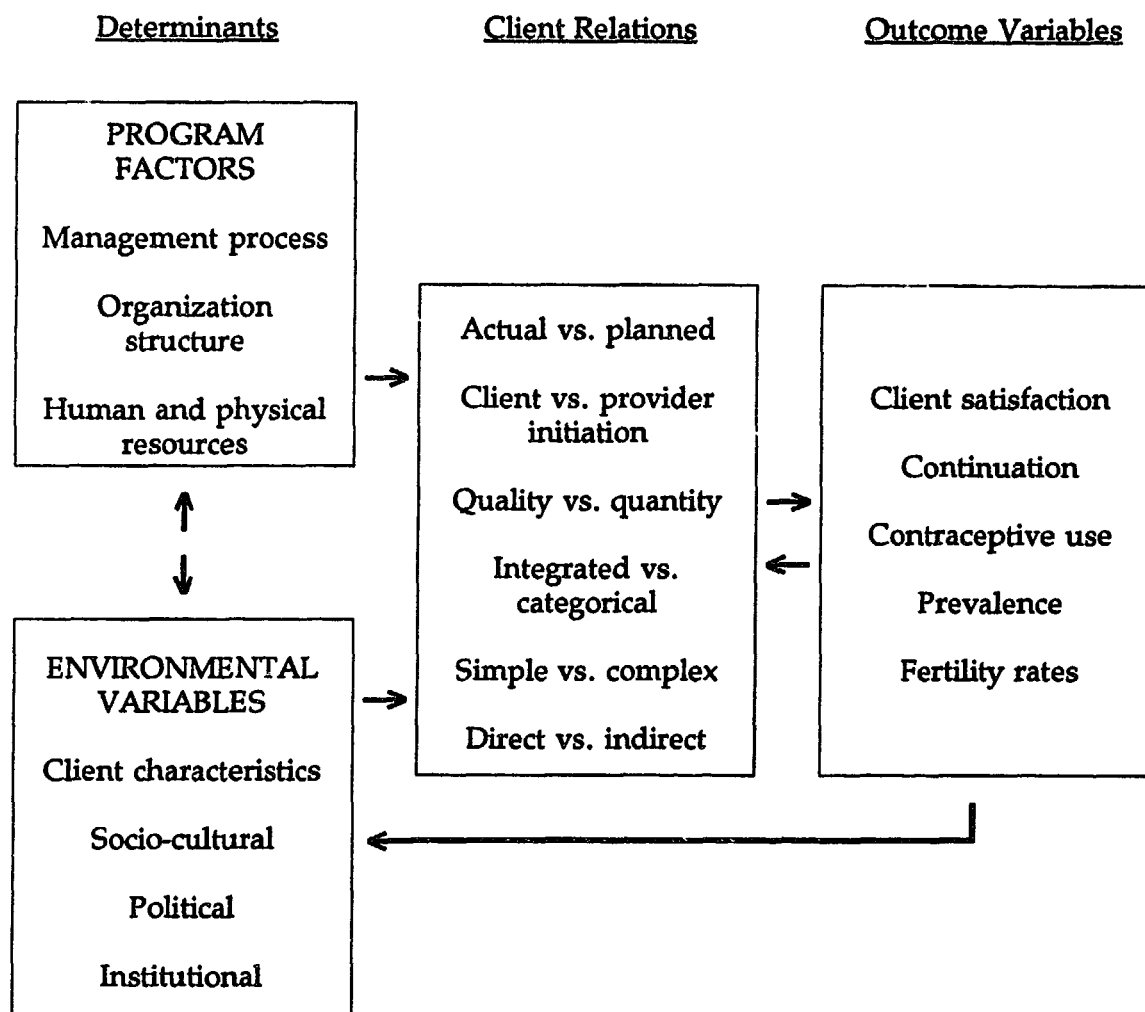


Figure 2. The Determinants of Client Relations

involvement in the decision-making process, in addition to a host of other managerial factors.

- ii. *Organizational structure.* Family planning workers are representatives and members of formal organizational structures. The characteristics of these organizations will be reflected in their interactions and exchanges with clients. Examples of these characteristics include the autonomy of different staff members and units, the degree of centralization of power and decision-making authority, reporting relationships, levels of hierarchy, differentiation, integration and coordination.
- iii. *Human and physical resources.* The human and capital inputs to the interface between programs and clients are important determinants of the nature of

client relations. In addition, total program resources will influence the managerial context in which client relations are embedded. This category of resources covers factors such as staffing, supplies, equipment and worker-patient ratios.

- iv. *The environment.* This category refers to a broad range of variables pertaining to the extent to which the nature of the institutional, social and cultural conditions in the environment of the health service delivery organization affects client relations and their operational determinants. Specific variables included are the scope, diversity and certainty of the client environment, the nature of the demand for family planning services, and their acceptability with the socio-cultural setting. The environmental variable also encompasses the political will, and other opportunities and constraints in the resource environment of the delivery system, as well as other relevant sectors.

### III. Improving Systems: A Review of Organization Development

Techniques to improve client relations can address either the client-provider interface directly, or seek to affect the system of determinants. Additionally important is the envisaged scope of change. There are several questions that can be posed about the proposed impact of interventions. Is a singular intervention planned to "fix" a disfunction, or is a continual program modification and growth intended? Who will be affected by the change? Who or what will be responsible for initiating and overseeing the course of action? How much of the organization will be involved in the change process? What are the goals of intervention, for the near future, in the long run?

**Organization development.** These questions concerning systemic change to improve and maintain program performance are addressed in the body of literature on organization development (OD). According to one definition, organization development is "any planned, organization-wide effort to increase the effectiveness and health of an organization through various 'interventions' in the organizational process" (Lippit, 1982:xiv). Organization development comprises a continual cycle of problem diagnosis, action/intervention, evaluation of the effects of these actions, and, above all, an ongoing maintenance of this process (French and Bell, 1978). Under a system of OD, specific obstacles and dysfunctions may be redressed and resolved, but the larger process of development never ceases. It is our contention that, in the long run, this is the only viable option for improving and maintaining client relations, situated as they are at the intersection of so many complex systems.

The OD literature contains much relevant wisdom to this discussion of techniques to improve the client-provider interface. The most important of these is a systems view of organizations, which complements the framework of determinants of client relations outlined above. OD practitioners recognize that organizations have life cycles and vitality, and are composed of and molded by interrelated, connected and interdependent systems. Issues, events, forces and other incidents, including interactions at the client-provider interface, are not isolated phenomena (French and Bell, 1978). Therefore, their repair cannot be accomplished in a piecemeal fashion,



because the superficial intervention that fixes relations today may not last when unsustained by the determinants of those relations.

The process of OD is intensely goal-oriented, and characterized by detailed planning to achieve these goals. OD is a data-based approach to planned change designed to solve problems. The aim of OD is really two-fold: rectify specific problems manifested in the system, while simultaneously improving long-term problem solving capacity of the organization. The cycle of diagnosis, action and evaluation itself must be institutionalized to insure its persistence and the overall vitality of the organization.

Once OD within an institution is mature and established, it is perpetuated by mechanisms to foster its continuation. But, prior to this end state, how does an institution begin system-wide change? The definition cited above notes "various interventions into the organization process." These interventions can be considered analogous to the techniques which are the subject of this paper. These techniques for improving client-relations, while aiming for improvements at the client-provider interface, are most important for their role in motivating a process of systematic self-examination and planned change, as entry points into OD. Their success in initiating this change will depend largely on the suitability to the institutional context. Prior to selecting and using a technique, one needs to pose, therefore, certain sets of questions: "What actually transpires at the interface between client populations and program representatives?"; "What is wrong at this level of program functioning?"; "What are the contributing factors to these dysfunctions, at this level, at higher levels of organization and administration, in the environment?"; and "How do the available techniques relate to the problems and constraints just identified?". This process of observation and diagnosis is a crucial part of OD, that in practice may often be overlooked.

OD emphasizes the notion of change agents or catalysts; individuals or institutions, often outside of the prevailing organization, who facilitate and advocate change. This function can also be performed by an inside body, provided that the management culture is convinced of, and receptive to, a flexible approach to organizational change. While change agents have long term relationships with organizations to maintain OD, the role of an outside agent may diminish over time as internal agents take over. When appropriate to the program as a whole, techniques can serve as these external change agents by initiating and catalyzing the process of planned change. If these techniques sensitize decision-makers to the need for change, motivate innovation, and legitimate the change process, then they are successful.

**Social learning theories.** A separate body of literature offering insight into systemic change in organizations concerns development administration theory, whose themes are not dissimilar to OD. The strategy of an adaptive development administration to solve problems has been characterized as an "incremental process of social interaction, trial and error, successive approximation and social learning" (Rondinelli, 1983:128). This latter notion of social learning is particularly germane to development administration, which places a heavy emphasis on using accumulated experience, rather than scientific management, to develop theories and apply them as remedial actions. The results of these actions are then examined and used as a basis for future intervention, continuing the cycle of change. Key to the institutionalization of this

learning-based administration is the ability to question existing realities and practices, and the willingness to initiate change. Similar to OD, development administration and social learning are rooted in a systems view of organizations that treats programs as wholes.

These two traditions have much to offer to a discussion of techniques designed to improve the interactions between programs and their beneficiaries. As established in the preceding framework, client relations are the product of numerous systems, and techniques for their improvement must therefore address these systems. These two bodies of literature concerning improving systems and strengthening their problem-solving capabilities offer a comparable framework for addressing client relations. Any techniques for improving client relations can reasonably be judged on their relationship to this process, and their ability to motivate this cycle of organization development and change.

**OD illustrated.** Real life experience with using OD to improve client relations was gained by the MCH-FP extension project in Bangladesh (Phillips et al., 1984; Simmons et al., 1990; Simmons et al., 1987). The extension project was commissioned by the government of Bangladesh to explore the feasibility of replicating elements of the highly successful Matlab project within the national family planning program. Because part of the mandate of the experiment was to implement the project through the government bureaucracy, adaptive implementation and organizational issues were of central concern. From its initiation, the project sought to pursue an OD agenda to facilitate effective client relations. Components of this focus included creation of an action-research capacity within the government, use of the findings to guide policy and a systemic progression of research and intervention to develop an organizational capacity for effective program implementation. In addition, there was emphasis on understanding bureaucracies as complex organizations of systems, and looking to see where within these systems there was scope for change. To reinforce this systems view, the process was a collaborative one, involving cooperation and involvement within every layer of the administrative bureaucracy (Simmons et al., 1987).

While the experiment was oriented towards change from its beginning, it was undertaken within the context of the already existing bureaucracy. There was a need, therefore, for a technique to initially motivate the change process. A training workshop, which forced supervisors and managers to focus their attention on their field staff, ultimately fulfilled this role. After observing for the first time field conditions and the determinants of worker performance, decision-makers were motivated to undertake systemic, organizational change within the program. A discussions of other results from this project, as well as exploration of how selected techniques in different settings can perform this same function as entry points into OD, are included in the following discussion of specific techniques.

#### IV. Selected Techniques for Improving Client Relations

The following four sections describe selected techniques for improving client relations, with emphasis on their potential as entry points into program and organi-

zation development. These four techniques, which represent more of a continuum than four distinct and mutually exclusive formulas, are not meant to be exhaustive. They are merely a selective sampling of some of the wisdom and experience that can be brought to bear on dysfunctional client relations. None of these "techniques" has universal application. Some are designed for use in specific program types, such as Patient Flow Analysis or Training and Visiting; others may have a broader scope. In addition, it is important that the status of current relations be understood before any techniques are used to modify them.

### ***Patient Flow Analysis (PFA)***

**The nature of PFA.** Patient flow analysis, or PFA, is a self-administered time-and-motion diagnosis that allows computerized documentation of patient flow and personnel utilization in health service clinics. The system, which was developed in the United States by the U.S. Centers for Disease Control, processes data gathered in one clinic session to create a graphical and tabular illustration of patterns of patient and staff interaction in a given clinic. The data collection exercise makes use of five separate forms, only one of which is actually completed while the clinic is in process, to cull information on, among other variables, patient arrival as related to appointment time, client service time relative to total time spent in the clinic, mean personnel cost per patient by visit type and personnel utilization in clinic by task. The system seeks to obtain a representative snapshot of the program and its dysfunctions, replicating a "typical" clinic session. Data collection is designed to be relatively unobtrusive, so as not to disturb the normal flow of clinic operations, and requires only a low level of skill and no previous experience on the part of clinic staff.

Once the information on clinic use has been collated, this data is processed in two computer programs, if necessary by an outside agency with the requisite computer facilities. The resulting easy-to-comprehend graphs and tables indicate patient flow bottlenecks, efficiency of staff use and relative per-visit costs by appointment type. This information then can serve as the basis for 1) diagnosing and defining problems of patient flow and personnel use, 2) hypothesizing their causes, 3) developing and implementing solutions and 4) evaluating the results of corrective actions, through follow-up studies (Hudgins et al., 1982).

**Relationship to the client-provider interface.** To understand how a diagnostic instrument could instigate a process of change that improves client relations, it is important to consider the possible effects of its use. The primary aim of PFA is to gauge and improve clinic efficiency in terms of both patient and personnel time and cost. While designed essentially as a tool for providers and managers to streamline operations, the system does purport to include a client perspective and to address areas of client satisfaction. Probably the single greatest benefit of PFA generated changes is a reduction in client waiting time for services, often due to a modification of appointment systems, and changes in the use of personnel. Such an improvement is of particular importance in many developing countries, where a visit to a family planning clinic often entails a major investment of time and resources, and a significant disruption of daily activities.

Experience with PFA has shown that clinics gain credibility when services are offered in a reasonable period of time and clients are not turned away (or leave on their own accord) as a result of delays of several hours or more. Women who have traditionally found the lengthy wait preceding services unacceptable may have one important obstacle removed with a reduction of waiting times and a greater likelihood of receiving care at each visit, thus widening availability of services. Greater cost-efficiency on the part of providers can lead to more women served, and/or a greater range of services offered, out of the same limited resource pool.

**Appropriate program types.** In addition to its limited application to only certain types of problems, PFA will only be of use in certain types of programs, those where a functioning system of public or private clinics are a key mode of service delivery. Because PFA measures patient flow through a clinic, it can only be used in settings where more than one provider is present. Many of the remedies advocated by PFA are simply not applicable to community based family planning outreach workers whose clients do not make regular use of a clinic. Even so, in many settings which use clinics, flow of patients is not necessarily the major bottleneck. Other problems, such as lack of drugs, unqualified staff and personnel who cannot be relied to appear on a regular basis, all impact upon the interface.

**Application to Third World family planning programs.** While PFA was originally developed for use in US clinics, the system has been successfully applied and tested in several developing countries, including, among others in Latin America, El Salvador and Brazil. In Costa Rica, in part as a response to a 1981 survey in which women cited long waiting times as the major reason for not using public clinics, a nationwide PFA program was begun in 1985. Nearly all public clinics participated in the effort, sending staff to relevant workshops and collecting clinic use data to be processed at the Costa Rican Demographic Association and the CDC. In approximately 40 percent of participating clinics favorable results were obtained through modifications of dysfunctional appointment systems or slight changes in staffing. Average waiting time for clients decreased by 65 minutes per patient, and the percentage of staff time spent in contact with clients increased (Hudgins et al., 1988).

**Potential for initiating change.** The Costa Rican experience is an excellent illustration of the weaknesses of patient flow analysis. More than half of the clinics that conducted a PFA did not opt to capitalize on the exercise. That is, they did not investigate the causes of bottlenecks illustrated in the output, and try to address them. The diagnostic exercise itself was not sufficient in those instances to motivate a process of change. Why PFA was an inappropriate entry point to OD, and what other techniques might be capable of motivating change, are central questions to be addressed in these cases.

In general, PFA is useful for revealing or pinpointing operations problems within a fundamentally appropriate system, and for suggesting possible solutions, such as altering an appointment system, to address them. Even if it is successful in diagnosing problems and their determinants, however, PFA will be of little use where changes to improve patient flow are beyond the control of clinic administrators. When PFA succeeds in improving client relations, it is because this level of intervention focused

decision-makers' attention on managerial determinants of problems at the interface. PFA will be less helpful, however, where programs and clinics themselves are fundamentally inappropriate in design for given service demand and supply constraints. A clinic that offers inappropriate services, or even relevant services at inappropriate times, will not have its problems revealed or solutions facilitated by PFA. In other cases, however, it could be argued that PFA serves to legitimate desired policy changes. Often the sources of clinic disfunction are readily appreciable to staff members, but a neutral and external scientific tool may lend the missing credence to efforts to address them.

**Summary.** PFA, on its own, is a diagnostic tool that documents patient flow, clinic use of personnel and cost. It describes certain aspects of client relations, specifically unproductive time for both clients and providers. This documentation is not in itself an intervention to change these relations, but is intended to provide the basis for a set of needed managerial changes. The role of PFA as a diagnostic tool is entirely consistent with the process of OD described earlier. The process of improving client relations has to begin always with observation and analysis of the actual nature of the interface. If PFA, through its documentation of client relations, subsequently motivates a process of change within the determinants of these relations, then the technique is an appropriate and successful one.

### *Training and Visit (T&V)*

**The nature of T&V.** Training and Visiting or T&V is an approach to restructuring community-based worker outreach programs along very specific organizational and administrative guidelines. This technique was originally designed for agricultural extension projects, but can be applied to a family planning outreach program. The system is guided by four mutually reinforcing principles: singleness of purpose, concentration on key tasks with frequent in-service training; regularity and predictability; and face-to-face communication. A proposed adaptation of the agricultural T&V program to health, population and nutrition suggests the following six elements: concentration on a small number of key tasks; a performance reporting system that focuses on these same tasks; regularly scheduled and frequent home visits by outreach staff; prioritizing certain categories of potential clients for focused attention; regular, frequent field supervision visits with a supportive theme; and regular in-service training (Heaver, 1984).

A sample T&V program for family planning might take something of the following form: Literate workers, familiar with the project area, receive intense training in one to three focused program messages that have been determined most relevant to the setting and well matched to client desires. Ideally workers are not to be encumbered with significant reporting and record keeping burdens, or supply distribution, but focus only on their well-internalized themes. Worker visits are rigorously scheduled on a day of the week basis, so that interaction from the clients' perspective is regular and predictable.

T&V staff meet with groups, rather than individuals, to ensure maximum effective exposure, and to encourage informal message dissemination by contact women. Regular visiting schedules also facilitate supervision and worker accountability.

In a T&V program supervisors should know exactly where to locate workers on any given day, and are expected to spend the bulk of their time in the field, accompanying workers on their rounds and offering supportive and intensive supervision. Supervisor to worker ratios are low, somewhere on the order of eight to one. Field supervision is also intended to provide a mechanism for regular face-to-face contact between staff and supervisors and immediate job feedback, thus eliminating much of the need for an elaborate upward reporting system. Regular in-service training sessions, either fortnightly or monthly, are included in each workers' schedule, and these training sessions ideally closely parallel the few well-outlined program messages and goals.

**Relationship to the client-provider interface.** Rather than focusing on worker selection and broad, ambitious program targets, T&V is concerned with what workers should actually be doing with their time in the field. The relationship between the intervention and the interface is more salient here than with PFA. The system is centered on presumed client needs, and is premised on flexible messages that constantly adapt to reflect changing local conditions and concerns. In agriculture, this flexibility takes the form of different messages for each phase of the growing season, as well as advice that complements local culture, diet, soil and weather conditions.

At the core of the T&V model is an intense preoccupation with the program-beneficiary interface. One of the goals of a T&V system is that all clients be able to spontaneously name their worker and the day of the week he or she always visits, as well as identify a few themes from their most recent encounter. The program is deliberately kept simple and focused to avoid overloading either client or provider with extraneous information. T&V, therefore, offers a direct mechanism for focusing decision-makers on client relations and their determinants, and a specific formula for restructuring the system of program outreach.

**Appropriate program types.** T&V has been defined as a "managerial approach for dealing with geographically scattered outreach operations" (Heaver, 1984:i). If PFA is an appropriate improvement technique for more developed urban family planning clinics, then T&V is an alternative mechanism for the opposite end of the spectrum, the rural community outreach program. T&V, when applied to health and population objectives, seeks to develop and adapt basic health and family planning services and health messages, primarily preventative behaviors, to local conditions, to reach very large numbers of disperse and poorly educated staff and beneficiaries, and so is most appropriately applied to field programs.

**Application to Third World family planning programs.** Much of what is written about T&V for family planning is hypothetical, because this system was not originally intended for health service delivery. Indeed, there are numerous obstacles to adapting the T&V model to family planning and health care outreach, some of which will be discussed later. One nutrition project in Tamil Nadu, India, however, best approximates this system in health services setting. In Tamil Nadu, two categories of health outreach staff, multipurpose health workers and community nutrition workers, make regularly scheduled visits to a subset of the population to spread simple nutrition messages. There are several facets of this program that are similar to T&V, including task

concentration, regular visit schedules, close supervision and opportunities for worker-to-worker and worker-to-supervisor communication (Heaver, 1984).

**Potential for initiating change.** To accurately judge the potential of T&V to serve as an entry point in OD, one must separate the principle of this technique from its specifics. T&V, as a specific technique for improving client relations, offers a plan of action for changing programs, in lieu of a diagnosis of their problems. This plan will only be successful if the proposed changes are suited to the determinants of problems in current client relations. As stressed earlier, *all* interventions in program design must be preceded by observation and understanding of the sources of dysfunctions at the client-provider interface, to determine where interventions are best addressed. The T&V program of outreach is not intended for application across the board to all instances of poorly performing rural extension projects for family planning, only those that might benefit from a restructuring of this nature.

There are other obstacles to applying this specific formula for restructuring indiscriminately to all outreach programs, which should be briefly noted here. The demand for family planning services, always a major stumbling block in project outreach, will not be as significant or as tangible as that for agricultural assistance, which is more visibly tied to the economic well-being of the household. Family planning messages do not change with the seasons, but they are more personal and involve more deeply entrenched cultural behaviors. In addition, family planning and health outreach in general is a more complex endeavor than agricultural outreach, entailing more detailed record keeping requirements, often more distribution of supplies, and a wider variety of potential services. Most important, evidence indicates that establishment of trust between workers and clients through closer social relations is a key factor in the success of outreach workers, particularly where family planning continues to be a sensitive topic. Workers must use every technique and theme they can to develop this trust, and mechanistic efforts to promote only a few themes may undermine this effort.

Nonetheless, exploration and consideration by decision-makers of T&V can play an important role for even those programs where its specifics are inappropriate. T&V represents a systems approach to managing client relations through restructuring several determinants of workers interactions with clients—not only do workers receive in-service training, but also facilitative supervision, and appropriate schedules, materials and messages. If T&V can assist program personnel in adopting a systems view of their own organization, encompassing not only the interface but the many factors that contribute to it, then such a technique may be very successful in initiating the process of observation, action and evaluation crucial to long-term change. It may not be so important that programs follow the exact format of a T&V program in order to improve client relations, but that they, in subsequently examining their own management and delivery systems, are capable of modifying T&V to induce systemic change appropriate to extant client relations and their determinants.

**Summary.** While T&V is more attentive to client-relations as a part of a complex system of determinants and intervening administrative variables than PFA, it too is only successful if it initiates systemic change. If a dysfunctional outreach program is hampered only by an inappropriate program design while situated within a politically,

demographically and financially supportive environment, than a switch to T&V may improve program performance and the interaction between staff and beneficiaries. There still remain, nonetheless, many of the traditional obstacles to effective home-visit program outreach.

However, because T&V is by design systemic in orientation, it may indeed provide the necessary impetus to programs to examine and modify their own systems. There are three underlying principles of T&V which experience has shown to be beneficial to worker efficacy at the level of the interface. These are identification of key messages, based on client needs, and insurance that their content is simplified, clarified and important; regularity of contact between clients and program representatives; and regularity of field supervision and establishing systems of monitoring this process. In some cases the specific T&V formula may be an appropriate mechanism for instituting necessary change and development within programs. In others, it may merely define a framework relating worker interaction with clients to its determinants. These three themes of key messages, regular client contact and supervision—visiting—are tested tenets of this framework that have met with success.

### *Activity Planning*

**The nature of activity planning.** Activity planning is a several step formula for improving program impact that comprises data collection and analysis, planning, training and implementation. The goals of the system are interactions with clients that are preplanned by objective and have an appropriately tailored communication scheme, special target activities for different subgroups of clients, and tighter program supervision. The first step of the activity planning process focuses on the data collection and analysis system, which forms the foundation of any successful planning endeavor. Before activity planning can transpire, therefore, information and record keeping activities must be strengthened and refined to yield usable management information systems.

With more rigorous record keeping capabilities, data can then be culled on the specifics of each village or target area, including socio-economic profile, information on attitudes towards family planning, desired family size and intent to use contraception. This process is the second phase of activity planning. LDC populations are by no means homogenous in their composition, and client receptiveness to family planning can vary widely from locale to locale, subject to a whole host of factors, including the attitudes and behavior of opinion leaders, level of development, modernization and urbanization, literacy rates and local customs or beliefs. Experience in Matlab, Bangladesh has revealed, for example, that some villages are relatively more "difficult" or "easy" climates for effective program intervention. This profiling activity is designed to give workers and decision-makers an indication of the intervention needs of the target population.

In the third phase of the activity planning process, preliminary data collection on these areas becomes a mechanism allowing programs to profile individual villages and even couples or households according to their demand for family planning and their receptiveness to program interventions. It also identifies where special efforts are



needed so programs can plan activities accordingly. These client and village profiles can be used to identify couples who have poor health and family planning performance and target them for lengthier and more frequent contact, as well as predetermine the more difficult cases where a supervisor's support or intervention may be necessary. Population profiles also help determine which types of interventions may be most appropriate for different locations—low knowledge and low interest villages may need intense IEC activities, while workers in hostile villages may benefit from initially avoiding discussion of family planning and focusing first on health and child survival themes.

If a program is to be capable of accommodating special activities and targeting specific clients, then it must be by implication a flexible one. Activity planning, in this respect the antithesis of Training and Visiting, calls for an abandonment of rigid Time-Place-Movement schedules and specific messages, and in their place development of a fluid work schedule adapted to local conditions, client profiles and desired contact frequency between program representatives and clients. Planning client contacts can have spill over effects to the remainder of the program, and activity planning can facilitate planning for complementary inputs to client transactions, including supplies and supervisor time. Supervisors themselves must play more supportive roles, allotting their time judiciously to difficult cases and worker back-up, and not merely policing.

**Relationship to the client-provider interface.** Even more than T&V, activity planning is focused towards the client-provider interface in its orientation. The goal of activity planning is that, armed with a preplanned objective and message suitable to the individual client or village profile, workers will be more capable in convincing and interacting with their audiences through higher quality exchanges. Part of this orientation may include specific training for workers on conducting effective interactions with potential clients. Eight issues to be stressed in training on conducting client interactions include: 1) need for prior information on client family and attitudes; 2) building rapport with clients; 3) ability to gauge the mood of the client; 4) expression of empathy; 5) topic initiation, timing and relevance; 6) abilities to listen and respond; 7) message conviction; and 8) the tone, language and expression of the communication (Bhatnagar and Gupta, 1980). It is interesting to note that, with the exception of the first, all of these factors are related, at least tangentially, to the notion of quality of care, and describe some qualitative dimension of the interpersonal relationship between program representative and client.

While focusing on the client-provider interface, this process of planning also focuses on some of the programmatic determinants of client relations, including worker's knowledge and communication skills, record-keeping and monitoring systems, supervisors' behavior and the information available to decision-makers. Client profiling allows supervisors and directors to allocate themes and resources appropriately. Human and capital resources are more efficiently utilized when contacts are preplanned not only by objective, but by client type.

**Appropriate program types.** Activity planning is similar to T&V in that its goal is to rectify dysfunctional worker outreach programs. Despite the initial enthusiasm surrounding use of trained outreach workers to deliver health and family planning

services in the developing world, many extension programs have failed to achieve their once-promised potential and reach large numbers of women with services, or to induce appreciable increases in contraceptive prevalence. Interactions in these outreach programs between clients and program representatives, as noted above, are often poor, infrequent, inadequately supplied or even nearly nonexistent. Activity planning was conceived to improve worker-client relations in this type of field setting. Activity planning is a particularly appropriate technique for improving and refining client relations in field projects facing very large and diverse client populations, because of its capability of developing multiple intervention strategies.

**Application to Third World Family planning programs.** The activity planning process was proposed and implemented originally in one Indian primary health center to attempt to take maximum advantage of the interfaces between the program and clients, through planning, focus and refinement of client transactions. This one recorded experiment in activity planning, conducted at the Singhpur primary health center, arose in response to appraisals documenting the lack of planning and concrete objectives in the interactions between workers and local women. Following evaluation, the existing activity planning process for extension workers at Singhpur was deemed inadequate and avenues for strengthening it were proposed. Activity planning took the form of special service camps, with family planning information booths, but only in villages that had been identified as housing a large enough number of interested couples to insure program success in promoting family planning and developing a rapport between the worker and his or her respective service area.

In addition to inadequate or nonexistent planning of worker visits, observations at the Singhpur project found that workers were lacking the requisite communication skills to conduct effective client relations. Therefore, workers received specific training in client transactions, focused on both general communication skills and use of prior knowledge about client attitudes to plan an appropriate communication strategy to promote contraceptive use. Observation and documentation of transactions in the field showed that when workers had no objective upon entering into a client encounter, the exchange often could not be controlled by them, and deviated off on unrelated tangents. These documented interactions were used as training materials in conjunction with brief profiles of the villages and clients involved.

The experiment in activity planning at Singhpur had mixed results. The long-term effect of the training on client interactions, as measured in later observation and evaluation, appeared to be negligible, probably due in part to the extremely short (2-day) duration of the training sessions. However, the specially planned information booths were fairly successful in increasing awareness of the outreach effort, a programmatic goal (Bhatnagar and Gupta, 1980).

**Potential for initiating change.** Two important elements of OD-like change in institutions are 1) specific goals relating to program outcomes—client-relations—and 2) system-wide change within the determinants of these outcomes. In principle, activity planning includes both of these. In addition, this technique of documentation and appropriate action mirrors the process of observation, action and evaluation central to OD. Therefore, in a manner similar to that discussed concerning T&V and OD,

experimentation with the technique of activity planning could serve to focus program managers and administrators on the systems which produce client interactions, and inspire change in those systems.

In addition to being oriented toward some of the programmatic determinants of client relations, the activity planning system of profiling, planning and training is distinctly premised on the need to render provider inputs more appropriate to the client audience. As noted in our model of the determinants of client relations, there are really two systems that mold the interface; the system of supply and the climate of demand. Through its emphasis on data collection and profiling, activity planning may lead decision-makers to a more holistic view of the determinants of client transactions, and the avenues for initiating changes in them. Techniques that do not recognize factors external to programs acting upon client relations will be less successful perhaps in motivating change that is profound enough to effect and sustain real improvement.

There will always be, however, cases where activity planning will be undertaken with no eye to larger or more individualized intervention. In these instances, activity planning may be an insufficient change agent, failing to catalyze or instigate systemic change. Unmodified replication of the Singhpur experiment runs the risk of completely overlooking the unique sources of program dysfunction. There may be environmental and structural constraints, in the program and in the client population, that undermine efforts to plan and target intervention with innovative and non-routine activities. If applied to an already functioning program, data collection and profiling activities could be biased by an already contaminated population. Workers must cope with the legacy of their prior transactions with clients when attempting to apply new skills and techniques. For populations where family is still a sensitive or controversial topic, an isolated questioning on the topic, without explanation or complementary message and service delivery, may actually undermine program efforts.

Special projects may be conceived without an eye to maintaining long-term coverage and continuous quality of care services. Innovative and one-time activities, intended to supplement, may be indeed be substituted for a more comprehensive intervention strategy. And again, activity planning cannot even begin to address the many constraints to effective client relations beyond poor communication skills and uninformed transactions, not the least of which is a program climate often valuing meeting targets over improving relations.

**Summary.** In light of these criticisms, one point bears reiteration. No technique will be effective if it is applied myopically. Intervention strategies must be tied to the perceived source of program dysfunction. While specific techniques are only successful in the long run if they can instigate change as entry points into OD, they must still be appropriate for the unique dysfunctions of a program. Activity planning, on its own, is a system for developing special projects. Activity planning, as a jumping off point to organization development, offers a framework for considering both the system of supply and the climate of demand in modifying the determinants of client reactions.

### ***Training and Worker Empowerment***

**The nature of training.** Training is an activity that seeks to educate or develop proficiency in a given skill among its beneficiaries. As suggested by this rather broad definition, there are numerous forms that training interventions, in family planning and other programs, can take. Training can be either formal—planned workshops in special settings—or informal instruction by supervisors to workers, or among workers themselves. Training can be long or short in duration, it can be a regular part of the program, or a special activity. Some training is participative, other is authoritative and one-sided in the flow of communication. Recipients of training can be either active or passive during the education process, and trainers can come from inside or outside of the organization of interest. The goals of this training can either be narrow and discrete, for example, prepare staff to conduct a one-day survey exercise, or broad and long-term—improve the supervisory and decision-making skills of managers. The amount and complexity of information transferred in the training session can also vary significantly.

For the purposes of this paper, and the improvement of client relations, we are interested in one particular type of training, that which adopts an action-learning approach, is participative and seeks to empower workers, which will be discussed below.<sup>4</sup> Regardless of style, however, there is the additional issue of the content of training. Evidence has shown that there are certain facets of client-provider interactions that are traditionally weak, including interpersonal communication skills, technical quality of care and information given to clients. Technical training is one area that has been especially neglected in family planning service delivery (see, for example, Ward et al., 1990) that merits investment. Other weaknesses in client relations have been delineated above. The content of training can play an important role as an improvement technique, if it addresses these weak skills.

Action-learning training is a training methodology that entails recipients' participation in developing action plans to address program malfunctions, under the guidance of a facilitator or instructor (Maru et al., 1983). In such training, the participants assume an active role in activities to increase their overall professional skills and problem-solving acumen. This approach is similar in some ways to the intent of OD itself, which calls for investments and growth in organizations as whole entities, so as to improve their problem-solving capabilities. In contrast to discrete transfers of specific knowledge, action-learning and other participative, liberating forms of training seek to develop the determinants of the recipient's work efficacy—organization and communication skills, critical analysis, self-reliance, etc. Addressing these determinants of performance is expected to improve overall worker competence. "Mature" training of this type has been characterized as focused on improving performance rather than knowledge, practical vs. esoteric in focus, emphasizing learning skills, fostering self-motivation in the learning process, action-learning in style, and reinforced through application (Lippit, 1982).

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<sup>4</sup>For an expanded discussion of empowerment, see Zimmerman, 1990.

A related notion is that of empowerment of workers through training that is designed to increase worker's confidence and efficacy via development and encouragement of the individual. The hallmarks of such training are active roles for participants, open-ended dialogue drawing on experience and jointly defined concerns, mutual trust and respect between teachers and students and cooperation in the learning process. Ideally such training should be an established and on-going component of the program design, so as to reinforce new behaviors and messages.

To complement the goals of this style, such training must be practical, relevant and applied. Time spent on theory and methodology often comes at the expense of lessons directly tied to the field situation. Training activities must also devote energies to insuring the quality of services provided. Quality, however, is not a technique, but a value that must be reflected throughout an organization. Mere intervention at the level of program representatives will be less effective if quality interactions are not a program priority.

**Relationship to the client-provider interface.** According to the framework delineated above, client relations are determined by four categories of variables: management processes, organizational structure, human and physical resources and the environment. One of these, human and physical resources, is integrally related to training, especially training which seeks to empower its recipients. Training of this sort represents an investment in these human resources that help determine client relations.

Concomitant improvements in the quality of these human resources is the hypothesized mechanism by which training will enhance client relations. Whether or not this training will have any appreciable impact, however, at the level of the interface will depend on a variety of factors. These include the duration of the training, its relevance to areas of weaknesses—especially quality of care, and the other obstacles to worker performance. Quite often lack of worker knowledge may not be the sole determinant of inadequate worker performance. It is important that training not be undertaken without first observing the needs of the systems it is intended to impact.

Nonetheless, general observations of client transactions have often revealed that program representatives are hampered by poor communication skills, incomplete training and insufficient knowledge (see, for example, Rao, 1978; Maru et al., n.d.). Training that is discrete in application and objective may address some of these factors. However, there is a pervasive tendency to view training and complementary materials development as a facile solution to poor relations. There is a quantifiable sense of accomplishment in sending off X number of staff to a workshop to receive training in any of a number of subjects. More success may be achieved in the long run by training that approaches improvement of these human resources systemically, in a continuous fashion, by developing all their relevant skills.

**Appropriate program types.** In contrast to the other techniques discussed so far, there are no program types where training would be a structurally inappropriate intervention. Any program or organization can in theory benefit from application of training, providing that is appropriately tailored to the needs of that organization. As with all techniques, care must be taken to determine that the training offered is relevant

to the specifics of the program. This includes identifying workers' required tasks prior to developing the curriculum (Pyle, 1987). Training in motivating acceptance, for example, is more important for programs where transactions are provider-initiated than in a clinic model of health services delivery. Similarly, attention must be paid to uncovering the sources of problems training is designed to solve. In cases where there are causes other than poor worker knowledge and skill, many training interventions will be useless at best, if not accompanied by efforts to address other systemic barriers to effective worker performance. In addition to being appropriate, practical and relevant, training efforts must not be used as a substitute for addressing other problems within the system of supply.

**Application to Third World Family planning programs.** Nearly every program at one time or another has provided training to its staff, either on an initial or in-service basis. Indeed, special training sessions are a popular technique for attempting to boost program performance, launch new initiatives or even reward workers. The use of special training efforts in many instances, however, has often failed to produce any dramatic change in worker behavior (see, for example, Nessa and Hurrell, 1985). In general such efforts are discrete in scope, of very short duration and often fail to account for other determinants of worker performance. This lack of a systems view of programs and their representatives handicaps the long-term impact of any training activity. Training has also not focused on some issues of crucial importance, such as quality in interpersonal relations. More success has been achieved in programs where frequent and regular in-service training is an established part of the program design, such as specified in the T&V approach to outreach. Fortnightly training in the ICDDR,B family planning program in Matlab, for example, has been important in maintaining work skills (Phillips et al., 1984).

Nonetheless, there have been few experiments in using action-learning or empowering training as a means to improve programs, probably due in part to the more resource-intensive nature of this type of instruction, and the fact that its premises run counter to traditional relationships and ideologies underlying many program bureaucracies. One experiment in action-learning, conducted in Uttar Pradesh, is illustrative, however, of how appropriate training can be instituted in developing country programs.

The training experiment was part of a larger six year effort by the Indian Institute of Management to improve family planning and health service delivery in two states. The goal of the training was to institutionalize management training capabilities and to open communication throughout various levels of the organization. Its target audience, therefore, were the managers and administrators at selected levels of the bureaucracy. Prior to undertaking any training, however, the consulting team, who functioned in the capacity of external change agents, developed their own teaching materials based on observation and analysis of the field situation that workers in the program were facing. Training, which consisted primarily of action-planning workshops for district level officers and medical officers using real data from the field, was undertaken in step by step manner, so that higher level managers could be made aware of the new management approaches and techniques, as well as the expectations and problems of their subordinates. The goal was to foster a supportive atmosphere for

innovation by involving superiors. In addition, participants were asked to divide their proposed actions into those that could and could not be accomplished without support from superiors. Communication with subordinates and superiors, as well as peers, was a routine part of the exercise, as well as follow-up workshops to discuss successful and unsuccessful experiences innovating with new techniques, and to clarify or reinforce issues raised by these experiences.

Following the first round of the experiment, an attempt was made to evaluate the impact of the training on behavior of the participants. More than 65 percent reported that, after participating in the action-learning sessions, they had successfully innovated in their management style based on training experiences. The bulk of innovations were in the areas of personal style of relating to subordinates, planning of activities performance evaluation and community mobilization. Efforts to open communication throughout the organization were somewhat less successful, and other barriers to innovation still remained, including a top management not always flexible enough to adapt new policies and procedures (Maru et al., 1983).

**Potential for initiating change.** At first blush, training of family planning workers seems too broad and fundamental to be a specific "technique" for improving client relations. It is a general principle that the vast majority of organized intervention programs already include training in some form in their development and/or operations. At the same time, training seems too discrete an activity to be capable of fostering fundamental and continuous change. Indeed, training is often a component of other techniques for improving program performance. The success or failure of training as a technique for improving client relations will depend on its ability to motivate positive change within the determinants of these relations.

OD practioners have made use of training groups as change agents within organizations undergoing systemic development. The key to the success of such groups is that they be flexible, transitory and adaptive to the needs of a changing institution (Lippit, 1982). Similarly, training as a technique to improve client relations through organization-wide development must be adapted to the needs of specific programs. The standard model of removed and discrete instruction will be of little value in effecting long-term improvements in worker performance. To serve as an entry point into OD, training must in a sense parallel the process of OD, by addressing the level of determinants of worker skill, and not just their surface manifestation. Continual and systemic development of individuals in an organization is analogous to the development of that organization itself. Training for this development is one part of a larger system of change to remove obstacles to innovation.

**Summary.** Training, the most universal intervention discussed in this paper, can be an illusory inroad for change, because so much of the appeal of this technique lies in its discreteness. Many training programs, workshops and activities have failed to maintain a systems view of the determinants of provider behavior in client relations. Discrete transfers of knowledge will most likely not motivate real change. When training can serve as an entry point into OD are in those instances where its is rooted in action-learning, empowering methodologies that seek to develop the whole skills of the participant, and encourage his or her ability to innovate. In addition, this training must

focus on practical areas where skills are weak, especially technical and interpersonal quality of care. Such training will be most successful when it is complemented by other changes in the system of supply that support and facilitate innovation and quality of care.

## V. Conclusion

In our discussion of techniques to improve client relations, we have deliberately focused only on those that directly impact the interface between programs and clients, and not its determinants. As argued above, this interface consists of the proximate operational determinants of contraceptive use, the outcome variable of interest to program personnel. Therefore, changes in systems should legitimately be related to the interface. Changes related to the determinants of client relations are equally valid avenues for improving the systems that support client relations. In theory, all interventions to induce change in the system of supply can be explored in their impact on client relations, but such discussion is beyond the scope of this paper.

We have chosen to focus, instead, on interventions that relate to our framework of client relations. This framework poses three questions: 1) what is the nature of the client-provider interface and its dysfunctions; 2) what are the key causes of these dysfunctions; and 3) where are appropriate points for starting change to address these causes. The selected sampling of techniques we have discussed are designed to hone in on key weaknesses in client relations, and rectify them. Nonetheless, the source of this weaknesses may be more deeply rooted than the interface. Modifications at the level of the interface, to be effective, cannot be an end point of intervention, but instead motivate more fundamental, systemic change.

The techniques presented here have not been discussed as techniques per se, but as potential entry points into a process of OD. Efforts to find a well-defined, systematic, and scientific "bag of tricks" for improving client relations are bound to be disappointed. The sampling of techniques discussed here are illustrative, not definitive. There are no identifiable administrative or managerial techniques for improving programs and client relations in the same sense that there are demographic techniques for describing populations. Because of the nature of the complex issues latent in the program-client interface, particularly those relating to human behavior and formally created organizations, such techniques are a logistic impossibility.

Rather than prescribe specific formulae for change, therefore, we have instead opted here to advocate a *process* of undertaking change that is comprised of observation, analysis and identification of an appropriate entry point for intervention. In doing so, we have presented a framework useful for the task of characterizing client relations, understating their key role as proximate operational determinants and identifying their determinants. It is intended that this framework will facilitate efforts to clarify and analyze client relations, so as to more effectively improve them through organization development and systemic change.



## References

- Afzal, Hossain, S. Clark, Y. Hasan, and M. Koblinsky. 1987. "Household Delivery of Maternal and Child Health and Family Planning Services in Rural Bangladesh: An 18 Month Longitudinal Assessment During 1984-85." Paper prepared for presentation at the Fifth Annual Conference of Indian Medical Statistics, Srinagar.
- Ainsworth, Maria. 1985. "Family Planning Programs: The Clients' Perspective." World Bank Staff Working Paper No. 676. Washington, D.C.: World Bank.
- Beeson, D., H. L. Lipton, D. H. Minkler, and P. Lee. 1987a. "Client-provider Transactions in Family Planning Clinics." In R. J. Lapham and G. Simmons (eds.), *Organizing for Effective Family Planning Programs*. Washington, D.C.: National Academy Press.
- \_\_\_\_\_, M. F. Mitchell, H. L. Lipton, D. H. Minkler, and P. Lee. 1987b. "Client-provider Transactions in Community-based Family Planning Programs and the Outreach Component of Clinic-based Programs." In R. J. Lapham and G. Simmons (eds.), *Organizing for Effective Family Planning Programs*. Washington, D.C.: National Academy Press.
- Bennis, W., K. Benne, and R. Chin (eds.). 1968. *Planning of Change*. New York: Holt, Rinehart and Winston.
- Berelson, B. 1974. "An Evaluation of the Effects of Population Control Programs." *Studies in Family Planning* 5(1), January.
- Bhatnagar, S. C., and S. S. Gupta. 1980. "An Experiment in Activity Planning at Singhpur Primary Health Center." Indian Institute of Management, Ahmedabad, April.
- Bruce, Judith. 1987. "Users' Perspectives on Contraceptive Technology and Delivery Systems: Highlighting Some Feminist Issues." *Technology in Society* 9.
- \_\_\_\_\_. 1989. "Fundamental Elements of the Quality of Care: A Simple Framework." Population Council Programs Division Working Papers, No. 1, May.
- Bulatao, R. A., and R. D. Lee. 1982. "A Framework for the Study of Fertility Determinants." In R. A. Bulatao and R. D. Lee (eds.), *Determinants of Fertility in Developing Countries*. New York: Academic Press.
- Churchman, C. West. 1968. *The Systems Approach*. New York: Dell Publishing.
- Danet, Brenda. 1981. "Client-organization Relationships." In P. C. Nystrom and W. Starbuck (eds.), *Handbook of Organizational Design*, Vol. 2, *Remodeling Organizations and their Environments*. Oxford: Oxford University Press.
- Davis, K. and Blake, J. 1956. "Social Structure and Fertility: An Analytical Framework." *Economic Development and Cultural Change* 4(3).
- Department of Health and Human Services—Public Health Service—Centers for Disease Control. 1988. "Patient Flow Analysis in General Outpatient Clinics: Data Processing."
- Department of Health and Human Services—Public Health Service—Centers for Disease Control. 1986. "Patient Flow Analysis in General Outpatient Clinics: Instructions for Collecting Data." September.

- French, W., and C. Bell. 1978. *Organization Development*. Englewood Cliffs, N.J.: Prentice Hall.
- Gay, Jill. 1980. "A Literature Review of the Client-Provider Interface in Maternal and Child Health and Family Planning Clinics in Latin America." Washington: Pan American Health Organization.
- Glatzer, Maurice, Anthony A. Hudgins, Terrance M. Broadway, and Jean Munden. 1988. "Using PFA as a Management Tool to Integrate Patient Services." Paper prepared for the APHA meeting, Boston, Massachusetts, November.
- Graves, Jack, Anthony A. Hudgins, Jane Delung, Claude A. Burnett, Pauline Scanlon, and David Orentlicher. 1981. "Computerized Patient-Flow Analysis of Local Family Planning Clinics." *Family Planning Perspectives* 13(4):164-170, July/August.
- Hazenfeld, Y., and D. Steinmetz. 1980. "Client-Official Encounters in Social Service Agencies." In C. Goodsell (ed.), *The Public Encounter: Delivering Human Services in the 1980s* Indiana: Indiana University Press.
- Hazenfeld, Y., and M. Zald. 1984. "Client-Organization Encounters in the United States' Social Welfare Sector." Ann Arbor, Michigan: School of Social Work, University of Michigan.
- Heaver, Richard. 1984. "Adapting the Training and Visit System for Family Planning, Health and Nutrition Programs." World Bank Staff Working Papers, No. 662.
- Heaver, Richard. 1988. "Reaching People at the Periphery: Can the World Bank's Population, Health and Nutrition Operations do Better?" Policy, Planning, and Research Working Papers, No. 81. Washington, D.C.: World Bank.
- Hudgins, Anthony A., and Lucia Merino. 1988. "Computerized Patient Flow Analysis in Costa Rica." Paper prepared for the PAA Annual Meeting in New Orleans, Louisiana, April 21-23.
- Hudgins, Anthony A., Jack L. Graves, Betty W. Abbott, Ellen Rhone Blair, Catherine Meyers, and Paula Van Ness. 1982. "Issues in Family Planning Clinic Management." *Family and Community Health*, May.
- Jain, A. K. 1989. "Fertility Reduction and the Quality of Family Planning Services." *Studies in Family Planning* 20(1).
- Koblinsky, Marjorie A., S. G. Brechin, S. D. Clark, and Y. Hasan. 1987. "Work Routines of Field Workers: A Determinant of Service Quality in Bangladesh." Paper presented at the American Public Health Association meeting, New Orleans, Louisiana.
- Kumar, Sushil, A. Jain, and J. Bruce. 1989. "Assessing the Quality of Family Planning Services in Developing Countries." Population Council Programs Division Working Papers, No. 2.
- Khandwalla, P.N. 1977. *The Design of Organizations*. New York: Harcourt Brace Jovanovich.
- Lapham, Robert J., and George B. Simmons. 1987. *Organizing for Effective Family Planning Programs*, Washington, D.C.: National Academy Press.
- \_\_\_\_\_, and W. Parker Mauldin. 1976. "Contraceptive Prevalence: The Influence of Organized Family Planning Programs." *Studies in Family Planning* 7(2).

- Lippit, Gordon. 1982. *Organization Renewal: A Holistic Approach to Organization Development* Englewood Cliffs, N.J.: Prentice Hall.
- Lipton, H. L., R. Dixon-Mueller, and P. Lee. 1987a. "Client-provider Transactions: An Introduction and Conceptual Overview." In R. J. Lapham and G. Simmons (eds.), *Organizing for Effective Family Planning Programs*. Washington, D.C.: National Academy Press.
- \_\_\_\_\_, R. Dixon-Mueller, and C. Brindis. 1987b. "Transactions with Clients: Suggestions for Research, Training and Action." In R. J. Lapham and G. Simmons (eds.), *Organizing for Effective Family Planning Programs*. Washington, D.C.: National Academy Press.
- Maru, R., N. Murthy, J. K. Satia, and T. V. Rao. n.d. "Introducing Professional Management in Public Systems: Some Observations from IIMA's Research on Management of Population Programme." Indian Institute of Management, Ahmedabad.
- Maru, R., N. Murthy, and J. K. Satia. 1983. "Management Interventions in Established Bureaucracies." *Economic and Political Weekly* 17(35).
- Misra, B.D., A. Ahsraf, R. Simmons, and G. B. Simmons. 1982. *Organization for Change—A Systems Analysis of Family Planning in Rural India*. Ann Arbor: Center for South and Southeast Asian Studies, University of Michigan.
- Mita, R., and R. Simmons. Forthcoming. "Indirect Effects of Program Interventions: Family Planning Knowledge and Attitudes Among Adolescent Girls in Rural Bangladesh." University of Michigan.
- Nessa, Fazilatun, and M. Hurrel. 1985. "Evaluation of Paramedics: Quality of Care through Pre- and Post-Training Written Test." Operations Paper 41, MCH-FP Extension Project, ICDDR,B Dhaka.
- Paul, S. 1982. *Managing Development Programs—The Lessons of Success*. Boulder, Colorado: Westview Press.
- Phillips, James F., R. Simmons, G. B. Simmons, and M. D. Yumus. 1984. "Transferring Health and Family Planning Service Innovations to the Public Sector: An Experiment in Organization Development in Bangladesh." *Studies in Family Planning* 15(2), March.
- Panandiker, V. A. Pai, and S. S. Kshirsagar. 1978. *Bureaucracy and Development Administration*. New Delhi: Center for Policy Research.
- Pyle, D. 1987. "Provider-Client Interactions at the Periphery: What's Worked in Large-Scale Population, Health, Nutrition Programs in the Third World." Draft prepared for the PHN division of the World Bank.
- Rao, T. V. 1977. "A Study of Family Planning Worker-Client Transactions." Indian Institute of Management, Ahmedabad.
- Rondinelli, Dennis. 1983. *Development Projects as Policy Experiments*. New York: Methuen & Co.
- Simmons, Ruth, and James F. Phillips. 1992. "The Proximate Operational Determinants of Fertility Regulation Behavior." Pp. 181-201 in J. F. Phillips and J. A. Ross, *Family Planning Programs and Fertility*. Oxford: Clarendon Press.

- \_\_\_\_\_, and George B. Simmons. 1990. "Health Services Research as it Relates to the Introduction of New Contraceptive Technology." Paper prepared for the World Health Organization Steering Committee of the Task Force on Long-Acting Systemic Agents for Fertility Regulation, WHO, Geneva, May.
- \_\_\_\_\_, and George B. Simmons. 1990. "Implementing the Quality of Care: Challenges for Management." Paper prepared for the 1990 ICOMP International Conference on Quality of Care, Kuala Lumpur.
- \_\_\_\_\_, Laila Bagee, Michael A. Koenig, James F. Phillips. 1988. "Beyond Supply: The Importance of Female Family Planning Workers in Rural Bangladesh." *Studies in Family Planning* 19(1), January.
- \_\_\_\_\_, M. A. Koenig, and A. A. Huque. 1990. "MCH and Family Planning—User Perspectives and Service Constraints." Draft.
- \_\_\_\_\_, James F. Phillips, Michael A. Koenig, and A. A. Huque. 1987. "Implementation-Based Policy Development in Bangladesh." Paper prepared for the Annual Meeting of the Population Association of America, Chicago, April-May.
- \_\_\_\_\_, M. Koblinsky, and J. Phillips. 1986. "Client Relations in South Asia: Programmatic and Societal Determinants." *Studies in Family Planning* 17(6), November.
- Ward, Sheila, Ieda P. Sigit Sidi, R. Simmons, and G. Simmons. 1990. "Service Delivery Systems and the Quality of Care in the Implementation of Norplant in Indonesia." Report prepared for the Population Council, New York, February.
- Zimmerman, Mark. 1990. "Empowerment: Forging New Perspectives in Mental Health." In J. Rappaport and E. Seidman (eds.), *Handbook of Community Psychology*. New York: Plenum Press.

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